# DBHDS
# CHARTER Statewide Cultural and Linguistic Competence Steering Committee

The Department of Behavioral Health and Developmental Services (DBHDS) calls for increased cultural and linguistic competence in Virginia's behavioral health care system. It is essential that all aspects of DBHDS be reflective of the diversity of the communities that we serve and that system stakeholders strive to become and remain culturally and linguistically competent. This requires incorporating skills, attitudes, and policies to ensure that the behavioral health care system is effectively addressing the needs of consumers and families with diverse values, beliefs, and sexual orientations, in addition to backgrounds that vary by race, ethnicity, religion, and language. The DBHDS advocates that all stakeholders be trained to reflect cultural and linguistic diversity as a basic civil right (USDOJ, 1964)

## Background

The Statewide Cultural & Linguistic Competence Steering Committee (CLCSC) was formed in response to the demographic changes among racially, ethnically, culturally and linguistically diverse populations within the Commonwealth of Virginia. These changes are expected to challenge Virginia's behavioral health care system, where addressing their diverse behavioral health care needs has become a DBHDS goal. A recent report of the Surgeon General notes that, to maximize effectiveness, behavioral health care providers must understand better the culture of their patients, and the impact of cultural beliefs and practices on an individual's access and quality of care. Access and quality of care can be affected by the degree to which the behavioral health care system provides culturally and linguistically competent services.

As a result, the need for cultural and linguistic competency standards in behavioral health care programs increasingly has been recognized in order to provide for the sensitive and appropriate assessment, treatment, and care of persons from diverse backgrounds with mental health, intellectual disability, and substance abuse illnesses (USDHHS, 1999; NIMH, 2001). This requires a thorough understanding of the culture and language of substantial limited English-speaking communities (MHA 2006) (including deaf, late-deafened, hard of hearing, and deaf-blind, sexual minority and elder communities). In behavioral health care organizations, cultural and linguistic competence translates into improvement in quality health care (OMH, 2001). As Virginia's population continues to diversify, its overall behavioral health care system needs to be ready to provide cultural and linguistic competency effectively. The DBHDS vision for culturally and linguistically competent care is:

- Care that is given with the understanding of and respect for consumer's health-related beliefs and cultural values; and
- Staff that respect health related beliefs, interpersonal styles, and attitudes and behaviors of the consumers, patients, families, and communities they serve; and
- Leadership from administrative, management, and clinical operations that supports individualized assessments; and processes that result in a leadership and clinical workforce who are culturally and linguistically competent.

## Definitions

*Culture*: The thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups (OMH, 2001; NIMH, 2001).

*Cultural Competence in Behavioral health:* A set of compatible behaviors, attitudes, and policies that work together in a system, agency, or among professionals that makes possible effective work in cross-cultural situations (Cross, et al. 1989; Isaacs and Benjamin, 1991). Is the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities (Cross, et al. 1989).

*Cultural Competency in Behavioral health:* The acceptance and respect for difference, continuing self assessment regarding one's own or another culture, attention to the dynamics of difference, ongoing development of cultural knowledge and resources and flexibility within service models to work towards better meeting the needs of diverse populations (Cross, Brazron, Dennis, & Isaacs. 1998

*Culturally and Linguistically Appropriate Services*: The ability of behavioral health care providers to understand and respond to the cultural and linguistic needs brought by patients to the health care encounter.
*Disparity:* Health disparities are differences in the incidence, prevalence, mortality, burden of diseases and other adverse health conditions or outcomes that exist among specific population groups in the United States. Health disparities can affect populations groups based on gender, age, ethnicity, socioeconomic status, geography, sexual orientation, disability or special health care needs and occur among groups who have persistently experienced historical trauma, social disadvantage or discrimination, and systematically experience worse health or greater health risks than more advantaged social groups.

*Health Equity:* Achieving the highest level of health for all people. Health equity entails focused societal efforts to address avoidable inequalities by equalizing the conditions for health for all groups, especially for those who have experienced socioeconomic disadvantage or historical injustices. (Healthy People 2010, US DHHS)

*Language Access*- The National Center for Cultural Competence describes the principles of language access as: Services and supports that are delivered in the preferred language and/or mode of delivery of the population served; Written materials that are translated, adapted, and/or provided in alternative formats based on the needs and preferences of the populations served; Interpretation and translation services that comply with all relevant Federal, state, and local mandates governing language access; and Consumers that are engaged in evaluation of language access and other communication services to ensure for quality and satisfaction.

*Limited-English Proficiency*: Individuals who do not speak English as their native language and who have a limited ability to read, speak, or understand English.

*Linguistic Competence:* The capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities.

## ARTICLE I - NAME, PURPOSE

Section 1: The name of the committee shall be the Statewide Cultural and Linguistic Competence Steering Committee (CLCSC).

Section2 The purpose of the CLCSC is to advise the Department on culturally and linguistically appropriate policies and practices and provide recommendations to the Commissioner of the Department of Behavioral Health and Developmental Services in effort to provide improved services to consumers and work toward eliminating disparities within the state's mental health, intellectual disability and substance-use disorder system.

## ARTICLE II – MISSION, AIMS AND GOALS

Section 1: The mission of the CLCSC is to work with the Office of Cultural and Linguistic Competence to enhance the ability of Virginia's behavioral health care system to effectively deliver linguistically appropriate and culturally competent health care to Virginia's populations.

Section 2: The aim of the CLCSC is to advise the Director of the Office of Cultural and Linguistic Competence regarding issues related to training, policies, and procedures that will enhance the Department's ability to provide a culturally and linguistically competent system of care. This committee will also provide legislative recommendations to the Commissioner of the Department of Behavioral Health and Developmental Services.

Section 3: The CLCSC goals are to :

- Disseminate the OCLC vision statement.
- Encourage and support opportunities for private providers, community service boards, community organizations, consumers, family organizations, and DBHDS staff to become partners in the steering committee.
- Disseminate a set of values, principles, and administrative policies that may enable stakeholders to work effectively cross-culturally.
- Make recommendations aimed at expanding the number of culturally and linguistically competent service providers, stakeholders, and staff within the public and private sector.
- Identify issues and provide technical support for ensuring access to language needs.
- Assist with the development of an annual plan to incorporate cultural competence as a critical component in key management activities including planning, quality management, contracts, and staff training.
- Assist in the development of statewide technical assistance and workforce training.
- Provide legislative and policy recommendations to the Commissioner of the Department of Behavioral Health and Developmental services.
- Identify relevant data elements needed to report program and service outcomes, measures, and identify progress.

## ARTICLE III – MEMBERSHIP AND MEETINGS OF MEMBERS

Section 1: Membership. Member of the CLCSC shall be appointed by the Commonwealth's Commissioner of Behavioral Health and Developmental Services.

Section 2: Terms: All CLSC members shall be appointed for one term, consisting of a four-year period. Members in good standing, having attended regular meetings, and actively support the CLCSC mission may request to serve one (1) additional term.

Section 3: Leadership. Formally, the CLCSC leadership shall consist of a Chair and Vice Chair. However, leadership from affiliates, stakeholders, advocacy agents, consumers, and other individuals throughout the State who work in committees and subgroups to complete the initiatives of the OCLC will be embraced and valued. Leadership shall serve a term of two years.

Section 4: Vacancies. When a vacancy on the CLCSC exists, nominations for new members may be received from CLCSC, OCLC, and the general public. Biographies will be included in the nominations. OCLC will send recommendation to the Commissioner in the fall for member installation in January of the following year.

Section 5: Resignation. Any member may withdraw from the committee at any time. The Commissioner of the Department of Behavioral Health and Developmental Disabilities shall determine need for replacement.

Section 6: Meetings. Regular meetings shall be held quarterly. A best effort will be put forth to accommodate a date and time most convenient for all members. All meetings are open to the public. Special meeting may be called by the OCLC or one-third of the CLCSC members.

Section 7: Attendance: This section is intended to support full contribution of all CLCSC members.

An attendance problem occurs if any of the following conditions exist in regard to a board member's attendance to board meetings:

1. The member has three un-notified absences in a row ("un-notified" means the member did not call ahead to a reasonable contact in the organization before the upcoming meeting to indicate they would be gone from the upcoming meeting).
2. The member misses more than 75% of the total number of board meetings in a twelve-month period.

*Note: There are some members, who may be affected by compressed work week schedules and required job responsibilities, (i.e. court appearances or required meetings), which may affect attendance. However, if the member is otherwise engaged in the committee and subcommittee work, then lack of attendance at quarterly meetings will not reflect any less commitment or active participation on the CLSC.*

Section 8 Subcommittees. The Chair appoints subcommittee leaders in consultation with Vice-Chair. The Chair is responsible for ensuring that subcommittees meet, submit minutes, and keep the CLC SC abreast of plans and activities at each CLC SC meeting. Subcommittee leaders have a two year term that coincides with the elected Chair and Vice Chair. Standing and ad-hoc committees may be added as needed. Minutes shall be recorded at subcommittee meetings. Approved minutes will be posted on the OCLC website. Approved minutes will be verbally reported to the committee at the following regularly scheduled meeting.

Subcommittees are as follows:

- **Community Engagement/Awareness**
  - The purpose of this committee shall be to identify opportunities to address inequities and stigma in mental health and developmental services and make recommendations to the CLCSC membership to support community actions addressing these issues.
  - The Chair-appointed leader and other volunteer subcommittee members determine activities, including the time and place of subcommittee meetings.
- **Data**
  - The purpose of this committee will be to assist OCLC with relevant data collection and to make recommendations to the CLCSC for policies and guidance around the collection of data to evaluate disparities in the system as well as evaluation of the impact of the work of the CLC.
  - The Chair-appointed leader and other volunteer subcommittee members determine activities, including the time and place of subcommittee meetings.
- **Training**
  - The purpose of this committee will be to identify and assist with implementation of relevant system training that will advance the reduction of disparities in care for individuals with mental illness and developmental disabilities.
  - The Chair-appointed leader and other volunteer subcommittee members determine activities, including the time and place of subcommittee meetings.
- **Legislative/Policy**
  - The purpose of this committee shall be to assist with the development and evaluation of policies related to culturally and linguistically competent practices. This committee shall also make recommendations on legislation, policy and procedures that impact equity to the CLC SC on issues that ultimately will be forwarded to the Commissioner of the Department of Behavioral Health and Developmental Services.

- The Vice Chair and other volunteer subcommittee members determine activities, including the time and place of subcommittee meetings.

Section 9: Notice. Notice of each meeting shall be given to CLSC members, by email, not less than ten days before the meeting, unless a special meeting is called by the OCLC.